Appendix 11a
Prior Authorization Request Form (PA/RF)
Spell of Illness Completion Instructions
(Physical Therapy)

Element 1 - Processing Type
Enter processing type 114, Physical Therapy (spell of illness only).

Element 2 - Recipient's Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

Element 3 - Recipient's Name
Enter the recipient's last name, followed by first name and middle initial, from the recipient's current identification card.

Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41) from the recipient's current identification card.

Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

Element 7 - Billing Provider's Name, Address, and Zip Code
Enter the billing provider's name and complete address (street, city, state, and zip code). *Do not enter any other information in this element since it also serves as a return mailing label.*

Element 8 - Billing Provider's Telephone Number
Enter the *billing provider's* telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 - Billing Provider's Medicaid Provider Number
Enter the billing provider's eight-digit provider number.

Element 10 - Recipient's Primary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description most* relevant to the service/procedure requested.

Element 11 - Recipient's Secondary Diagnosis
Enter the appropriate ICD-9-CM diagnosis *code and description* additionally descriptive of the recipient's clinical condition.

Element 12 - Start Date of Spell of Illness
Enter the date of onset for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 13 - First Date of Treatment
Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

Element 14 - Procedure Code(s)
Enter the procedure code as described in the plan of care.

Element 15 - Modifier
Enter the "PT" modifier appropriate for each procedure code.

Element 16 - Place of Service
Enter the appropriate place of service code.

Numeric	Description
0	Other
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

Element 17 - Type of Service
Enter the appropriate type of service code for each service/procedure/item requested. This includes therapy services and therapy spells of illness (Physical Therapy).

Numeric	Description
1	Medical
9	Rehabilitation Agency

Element 18 - Description of Service
Enter the appropriate procedure code description.

Element 19 - Quantity of Service Requested
Enter the number of treatment days requested, per procedure code.

Element 20 - Charges (leave this element blank)

Element 21 - Total Charge (leave this element blank)

Element 22 - Billing Claim Payment Clarification Statement
Please read the "Billing Claim Payment Clarification Statement" printed on the request before dating and signing the prior authorization request form.

> "An approved authorization does not guarantee payment. Payment is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Payment is in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid-contracted managed care program at the time a prior authorized service is provided, Medicaid payment is allowed only if the service is not covered by the managed care program."

Element 23 - Date
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

Element 24 - Requesting Provider's Signature
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

Do not enter any information below the signature of the requesting provider - This space is reserved for Medicaid consultant(s) and analyst(s).